TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Occupational Medical Care

Respondent Name
ACE American Insurance Company

MFDR Tracking Number
M4-16-0116-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
September 15, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Proof of Timely filing"

Amount in Dispute: $400.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Without sufficient evidence to support proof of timely electronic bill submission to CorVel's clearinghouse on behalf of the insurance carrier it is assumed the electronic medical bill was only submitted to the health care provider's bill processing agent not later than the 95th day…

CorVel received a paper medical bill for date of service 11/17/14 and 11/24/14 on 07/09/15 (234-days) which exceeds the 95-day statutory and regulatory requirements for timely filing."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 17 & 24, 2014	Evaluation & Management Work Status Report Radiology Supplies	$400.58	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for submitting medical bills.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.

4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – Time limit for filing claim/bill has expired
   - RM2 – Time limit for filing claim has expired
   - Note: "Per rule 133.20 and section 408.027 of The Act, your documentation does not meet the criteria for proof of timely filing. Document indicates your clearinghouse received the document. Corvel is not your CH. This bill was not received by Corvel timely."

Issues

Are the insurance carrier's reasons for denial of payment supported?

Findings

The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – "Time Limit for Filing Claim/Bill has Expired." Texas Labor Code §408.027(a) states that

> A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.

Further, 28 Texas Administrative Code §102.4(h) states that:

> Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:
> (1) the date received, if sent by fax, personal delivery or electronic transmission or,
> (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

Review of the submitted information finds no documentation to support that a medical bill was submitted to the insurance carrier within 95 days from the date the services were provided. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a). For this reason, the insurance carrier's denial is supported. No reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	October 6, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.